DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

LTC Residents Protection
NOV 30 2009
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085022	A. BUILDING _____ B. WING _____	C 09/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 9, 2009 through September 23, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 66. The survey sample totaled fifteen (15) residents, which included a review of thirteen (13) active and two (2) closed clinical records. Additionally, there were eight (8) subsampled residents.	F 000		
F 224 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide thorough, accurate weekly skin checks for 2 out of 15 sampled residents (R6 and R15). As a result, R6 had a delay in treatment and services for a trimalleolar fracture and R15 had a delay in treatment and services for a pressure ulcer. Findings include: cross-refer to F309, example #1 1. R6 was admitted to the facility on 10/11/02 with multiple diagnoses including advanced Alzheimer's Dementia, Parkinson's Disease, and Osteoporosis. She was non-verbal. Review of R6's clinical record revealed that a	F 224	A) Upon notification of incident all nursing staff were in-serviced on handling residents with "Severe Osteoporosis and Pressure Ulcers". 02/13/09. (See Attachment A.) Additionally, the nurse who failed to complete the weekly skin checks as assigned was counseled and in-serviced regarding her responsibilities with these weekly assessments. B) All residents have the potential to be affected by the deficient practice. A sweep was completed on 10/23/09 of the weekly skin check assignments. 66 out of 66 were properly completed as assigned.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
L C Mitchell	Administrator	10/26/09

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 weekly skin check was conducted on 1/18/09 and nothing was found on the resident's legs or feet. The next skin check was done two weeks later on 1/31/09, although facility policy stated they were to be done weekly. The skin check, dated 1/31/09 and timed at 8 AM, noted nothing on the legs or feet. On 1/31/09, R6's left foot and ankle was found to be swollen, tender to touch, and had yellow-red discoloration. R6 was subsequently sent to the ER and was found to have a left trimalleolar fracture. Review of the report from the orthopedic physician, dated 2/3/09, revealed, "As to the etiology of this fracture, it appears to be subacute, meaning it has probably been there for maybe 2-4 weeks." An interview statement, dated 2/1/09, by E14, the nurse who conducted R6's skin check on 1/31/09, the same day that the bruised, swollen, ankle and foot were discovered, stated that she found "...no swelling, bruising or discoloration L (left) ankle." The facility failed to conduct a thorough skin assessment on R6 for two weeks resulting in a failure to identify the fractured ankle which caused a delay in treatment. The fractures were subsequently casted. Findings were confirmed by E2 on 9/16/09. cross-refer to F314 2. Weekly skin checks, dated 5/10/09 through 5/31/09, documented an Allevyn dressing for protection in place on R15's sacral area, but failed to document an actual assessment of the skin area. On 6/14/09, 2 days after an	F 224	C) Supervisors to assess completion of assigned weekly skin assessment compliance. Supervisor will assure weekly skin assessment completed as assigned prior to end of shift. Supervisor will report to nursing management regarding failure of any nurse to complete this assignment as assigned. Appropriate staff will be in-serviced regarding this procedure by 10/31/09. D) Skin assessment sheets will be audited for each individual at their quarterly IDCC meeting and prn based on reported incidents concerning skin integrity. Any new concerns that arise regarding skin integrity will be identified to the wound care nurse for follow up assessment and treatment.	10/31/09 12/3/09

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F 224	Continued From page 2 unstageable sacral pressure ulcer was discovered, the facility again failed to assess the sacral area.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to ensure that allegations of misappropriation of property were immediately reported and investigated for two residents (R1 and R14) out of 15 sampled residents. Findings include: 1. R1 was admitted to the facility on 11/9/07 with multiple diagnoses including end stage renal disease and depression. R1 was hospitalized for a right leg amputation on 3/1/09. In an interview with the resident on 9/11/09, he stated that a nurse locked his laptop computer in the medication room for him while he was in the hospital. When he came back to the facility, he stated they gave him back his computer, however the network card which allowed him to have internet access was missing. He stated that he reported this to staff, but they were unable to find it. He stated that no one tried to find out what happened to the card. Since then, he sent his computer home with his sister as it was of no use to him since he could no longer access the internet. Interview with E8, a nurse, on 9/21/09, confirmed that R1 was missing his network card for his computer after it was locked in the medication room and that staff looked for it, but could not find it. She stated it was reported to the past unit manager. The facility failed to investigate and failed to	F 225	A). Residents R1 was provided a locked cabinet and key in his room to secure personal property on 9/22/09. Option available to all residents. Investigation initiated 10/22/09. Resident R14 is no longer at Emily P. Bissell Hospital. Incident report completed on 10/22/09 based on written documentation in nursing notes and investigation initiated based on information available. B). All residents have the potential to be affected by this deficiency. A notice to all residents/guardian will be sent regarding securing personal items, inventory resident belongings and reporting procedures to report any past or future losses. Any incidents reported will be investigated upon report and corrective action taken depending on findings. C) Update current incident reporting policy to define loss or damage of personal property as a reportable incident. Update the investigative procedure to include security involvement and investigation in all loss of property cases. Educate all staff on reporting requirements and updated policy and procedure.	10/31/09 10/31/09 10/31/09

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F 225	Continued From page 4 report this allegation of misappropriation of property. 2. R14 was admitted to the facility on 2/6/09 with multiple diagnoses including a history of stroke resulting in right-sided paralysis, congestive heart failure and diabetes. Review of R14's clinical record revealed a nurse's note, dated 3/4/09 and timed 2:10 PM, which stated, "Call from sister (name), inquiring about phone, unable to find." A subsequent note, dated 3/5/09 and timed 4:00 PM, stated, "Room searched, unable to locate cell phone." Review of the facility's incident reports for missing property since 1/1/09 lacked evidence that R14's missing item was reported and investigated, nor was it reported to the state agency. In an interview with E2, the facility administrator, on 9/21/09, she stated that staff were to report residents' missing property to her so she could conduct an investigation and report the incident to the state agency. She added that staff were inserviced regarding the kinds of incidents that needed to be reported, which included missing items. The facility failed to conduct a thorough investigation for missing property for R14 and the facility failed to report this allegation of misappropriation of property to the state agency.	F 225	D). Review of all incident reports to ensue complete follow through on process. Resident Council topic on a Quarterly basis as a reminder to residents regarding reporting procedure. Review of annual customer satisfaction surveys for any indication of a incident not reported. Review number of incidents and/or patterns for opportunities for continued improvements.	10/31/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	A) A lead protection plan and instruction will be provided by Harvard Environment listing rules of lead paint abatement procedures. The removal of lose lead paint, prep for painting, and painting will be undertaken through contract bid and completed by November 30, 2009	11/30/09

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F 225	Continued From page 4 report this allegation of misappropriation of property. 2. R14 was admitted to the facility on 2/6/09 with multiple diagnoses including a history of stroke resulting in right-sided paralysis, congestive heart failure and diabetes. Review of R14's clinical record revealed a nurse's note, dated 3/4/09 and timed 2:10 PM, which stated, "Call from sister (name), inquiring about phone, unable to find." A subsequent note, dated 3/5/09 and timed 4:00 PM, stated, "Room searched, unable to locate cell phone." Review of the facility's incident reports for missing property since 1/1/09 lacked evidence that R14's missing item was reported and investigated, nor was it reported to the state agency. In an interview with E2, the facility administrator, on 9/21/09, she stated that staff were to report residents' missing property to her so she could conduct an investigation and report the incident to the state agency. She added that staff were inserviced regarding the kinds of incidents that needed to be reported, which included missing items. The facility failed to conduct a thorough investigation for missing property for R14 and the facility failed to report this allegation of misappropriation of property to the state agency.	F 225	B) The Physical Plant Superintendent will make an inspection of the facility. Any additional areas found suspected of being lead paint will be tested by Harvard Environmental. If findings are positive a certified painting contractor will be employed to address the issues. None lead painted surfaces needing prep work and painting will be done in house. C) Physical Plant Maintenance Trade Mechanics will be instructed to identify areas in need of painting while conducting weekly rounds. Any additional areas found suspected of being lead paint will be tested by Harvard Environmental. If findings are positive a certified painting contractor will be employed to address the issues. None lead painted surfaces needing prep work and painting will be done in house.	11/30/09 11/30/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 225	Continued From page 4 report this allegation of misappropriation of property. 2. R14 was admitted to the facility on 2/6/09 with multiple diagnoses including a history of stroke resulting in right-sided paralysis, congestive heart failure and diabetes. Review of R14's clinical record revealed a nurse's note, dated 3/4/09 and timed 2:10 PM, which stated, "Call from sister (name), inquiring about phone, unable to find." A subsequent note, dated 3/5/09 and timed 4:00 PM, stated, "Room searched, unable to locate cell phone." Review of the facility's incident reports for missing property since 1/1/09 lacked evidence that R14's missing item was reported and investigated, nor was it reported to the state agency. In an interview with E2, the facility administrator, on 9/21/09, she stated that staff were to report residents' missing property to her so she could conduct an investigation and report the incident to the state agency. She added that staff were inserviced regarding the kinds of incidents that needed to be reported, which included missing items. The facility failed to conduct a thorough investigation for missing property for R14 and the facility failed to report this allegation of misappropriation of property to the state agency.	F 225	D) The Physical Plant Superintendent will make quarterly inspection of the facility. Any additional areas found suspected of being lead paint will be tested by Harvard Environmental. If findings are positive a certified painting contractor will be employed to address the issues. Non lead painted surfaces needing prep work and painting will be done in house.	11/30/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview on 9/9/09, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly interior. Findings include: Observations at 8:45 AM of the dry food storage room with E6, Food Service Director, revealed a wall with peeling paint. Additionally, the hallway ceiling paint near the dry food storage room was peeling. An interview with the director confirmed these concerns.	F 253		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 3 residents (R2, R4 and R6) of 15 sampled. R2 had a Resident Safety Sheet posted above her bed on 9/10/09 which incorrectly stated that she was to have a sippy cup and thickened liquids, however, her status was changed to nothing by mouth/ tube feeding	F 309		

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F 309	Continued From page 6 only in 4/09. Nursing staff discontinued R4's pain medication without a physician's order. Accurate skin assessments were not completed for R6 for at least two weeks resulting in a failure to identify her fractured ankle in a timely manner which caused a delay in treatment. Findings include: 1. R6 was admitted to the facility on 10/11/02 with multiple diagnoses including advanced Alzheimer's Dementia, Parkinson's Disease, and Osteoporosis. She was non-verbal. A nurse's note, dated 1/31/09 timed 6:30 PM, stated, "Called today (name) CNA (Certified Nurses Aide) to assess L (left) lateral malleous (sic-ankle) and foot - site edematous (swollen). yellow-red coloring noted around L lateral malleous (sic)- tender to touch..." The note stated that the physician was called and the resident was sent to the emergency room for evaluation. Review of the report from the orthopedic physician, dated 2/3/09, revealed that R6's x-rays revealed that she had severe osteoporosis with fractures of the left distal tibial and fibula (bottom of the leg). The report also stated , "As to the etiology of this fracture, it appears to be subacute, meaning it has probably been there for maybe 2-4 weeks." The facility's policy for "Weekly Skin Checks" stated, "Licensed staff is to complete head to toe skin checks on all residents weekly... bruising will be marked on diagram...". Review of R6's care plan, dated 1/9/04, for "Potential for injury: R/T (related to) osteoporosis", included the approach to "Report	F 309	R 6 A) Upon notification of incident all nursing staff were in-serviced on handling residents with "Severe Osteoporosis and Pressure Ulcers". 02/13/09. – (See Attachment A). R6 was seen by surgeon etc. B) All residents have the potential to be affected by the deficient practice. The care plans of all residents identified with severe osteoporosis and /or pressure ulcers were assessed to assure specific needs regarding this is reflected. This sweep was completed by 10/23/09 and no residents were found to be affected by this deficient practice. C) Unit Manager or designee to conduct audits on all weekly skin checks to ensure compliance. D) All audit results will be monitored by nursing supervisors and reported to the NQI committee for review until substantial compliance is achieved.	2/13/09 10/23/09 12/3/09

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F 309	Continued From page 7 and document any swelling, bruising, pain or discomfort." R6's care plan for "Potential for injury: R/T skin", also dated 1/9/04, included the approaches, "When providing daily care, check skin for possible new bruises, skin tears, etc." and "Nurse will check skin weekly and complete Braden Scale quarterly." Review of R6's clinical record revealed that a weekly skin check was conducted on 1/18/09 and nothing was found on the resident's legs or feet. The next skin check was done two weeks later on 1/31/09, although the facility's policy stated they were to be done weekly. The skin check, dated 1/31/09 and timed at 8 AM, noted a small red area on the top of the resident's right thigh, but nothing on the legs or feet. An interview statement, dated 2/1/09, by E14, the nurse who conducted R6's skin check on 1/31/09, the same day that the bruised, swollen, ankle and foot were discovered, stated that she found "...no swelling, bruising or discoloration L (left) ankle." The facility failed to conduct a thorough skin assessment on R6 for two weeks resulting in a failure to identify the fractured ankle which caused a delay in treatment. Findings were confirmed by E2 on 9/16/09. 2. R4 was admitted to the facility on 10/16/96 with multiple diagnoses including degenerative joint disease. Review of R4's physician order sheet, dated 8/3/09, revealed an order for a Lidoderm 5% Patch (for pain) to apply to the right shoulder in the AM and remove at bedtime.	F 309	F 309 R4 A) Once informed of incident, corrective action was immediately taken by obtaining a physician order to discontinue the medication.. (see attachment E) B) All residents have the potential to be affected by the deficient practice.	09/11/09

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F 309	Continued From page 8 Review of R4's Pain MAR (Medication Administration Sheet), dated 8/09, revealed an order for "Lidoderm Patch 5% to right shoulder on AM, off HS (bedtime). The MAR indicated that R4 received the medication through 8/14/09 and then it was discontinued. During an interview with R4 on 9/11/09, he stated that he no longer needed the pain patch for his shoulder. Review of physician orders revealed lack of an order to discontinue the Lidoderm Patch. In an interview with the unit manager, E5, on 9/11/09, she stated that the renewal for the medication was in place and a physician's order should have been obtained before it was discontinued. The facility failed to follow the physician's orders to provide the Lidoderm Patch for R4 and they failed to obtain a physician's order to discontinue the medication when the resident no longer needed it. A physicians order was written to discontinue the Lidoderm Patch on 9/11/09 after the issue was brought to the facility's attention. 3. Review of R2's diagnoses included schizoaffective disorder with psychosis, bipolar disorder and dementia. An annual MDS (minimum data set) assessment, dated 11/11/08, revealed that R2 had severe cognitive impairment and unclear speech. Review of the clinical record revealed a speech/swallow evaluation, dated 4/23/09, which stated that R2 was to be NPO (nothing by mouth). Review of the resident's tube feeding care plan, dated 11/1/06, additionally stated that she was NPO.	F 309 R4 F309	C) All nurses will be in-service regarding facility policy on discontinued medications by 10/30/09. A 24 hour physician order chart check will be conducted by nurses on the 11-7 shift to ensure compliance. D) Audit findings will be reported to the DON / NQI committee for review to ensure substantial compliance. R2 A) Once the facility was informed by the surveyors, the RN in charge removed the old safety sheet and immediately replaced it with an undated one to reflect R2's NPO status. B) All residents have the potential to be affected by the deficient practice.	10/30/09 12/3/09 9/10/09

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F 309	Continued From page 9 On 9/10/09, a Resident Safety Sheet was observed above R2's bed which stated that a sippy cup was to be used with nectar thickened liquids, although R2's changed to NPO over 4 months earlier. The incorrect signage placed R2 at risk for aspiration (liquids taken by mouth end up in the lungs which can cause choking and pneumonia). Findings were confirmed with E9 (RN) on 9/10/09 and a new Resident Safety Sheet with R2's NPO status was immediately posted.	F 309	C) Nurse taking off orders is to update safety sheets once there is a change in resident status. The RNAC/designee reviews all orders received. Upon receipt on an order indicating a safety sheet change, the RNAC will review the safety sheet in resident room and sign off on copy of the order that change is made. These orders will be kept for review at monthly NQI meetings. In-servicing regarding this change will be completed by 10/31/09.	10/31/09
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary treatment and services to promote healing of a pressure ulcer for 1 of out 15 sampled residents (R15). A facility nurse was asked by a CNA to evaluate R15's sacral area that had foul smelling drainage on 6/12/09. The nurse covered the sacral area with a dressing without cleaning the wound and the facility failed to ensure that the MD and RD (Registered Dietitian) were notified per facility policy. When the wound was reported on 6/15/09, 3 days later,	F 314	D) The NQI committee will review new safety sheet orders monthly. Findings will be reported to the DON for corrective action.	12/3/09

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F 314	Continued From page 10 the unit manager (E19) determined the wound to be an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar) pressure ulcer (PU). Weekly skin checks dated 5/10/09 through 5/31/09 documented an Allevyn dressing for protection in place on the sacral area, but failed to document an actual assessment of the skin area. On 6/14/09, 2 days after the sacral PU was discovered, the facility again failed to assess the sacral area. Findings include: Review of the facility policy entitled "Weekly Skin Checks" stated, "1. Licensed staff is to complete head to toe skin checks on all residents weekly... 3. If skin is not intact, licensed staff will document any alterations in skin integrity. Ongoing and new areas will be clearly marked each week. A nurse discovering a new area during skin check will note the area with a mark, make an entry in nurse's notes, report to the physician and supervisor and initiate treatment...". R15 was admitted to the facility in 1998. Diagnoses for this resident included end stage COPD (chronic obstructive pulmonary disease) and Alzheimer's disease. R15 was on hospice since approximately 1/06. A quarterly MDS (minimum data set) assessment, dated 5/26/09, listed R15 with moderate cognitive impairment with short and long-term memory impairment. She was non-ambulatory, incontinent of bowel and bladder and required extensive staff assistance with most activities of daily living. R15 was listed as having no pressure areas on the 5/26/09 MDS assessment or on the annual MDS assessment, dated 2/26/09.	F 314 R15	A) Upon notification of incident, the nurse was immediately removed from direct resident care pending outcome of investigation. Upon conclusion of the investigation, disciplinary action was taken against E 10. A one on one training with E on maintaining resident "Skin Integrity" was completed by the staff educator on 06/18/09 with E10. (See Attachment F). A Review and Refresher Training on Weekly Skin Assessments and Documentation was completed by all nursing staff by 06/25/09. (See Attachment B) The care plans of all residents identified with pressure ulcers were assessed by the wound care nurse to assure specific needs regarding this is reflected. R15 received preventative treatment to sacral area with the application of an Allevyn dressing and topical barrier creams to her buttocks. A low air mattress was use to relieve pressure to sacral area. Resident received fentanyl patch every 72 hours and morphine for breakthrough pain.	6/25/09

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F 314	Continued From page 11 Review of R15's care plan problem "potential for impairment of skin integrity- hx (history) sacral pressure ulcer", dated 4/15/05 and last revised on 3/5/09, stated, "Assess for S/S (signs and symptoms) of skin breakdown (i.e.- redness/darkness, unusual warmth, c/o (complaints of) pain or open areas) at least q (every) shift. Report abnormalities... R (right) buttock preventative treatment with Allevyn...". The care plan problem "alt. (alteration) in activity: turn & position r/t (related to) impaired physical mobility", last revised 3/5/09, listed the intervention "Nurse will assess skin weekly... Any skin breakdown will be reported to the MD and RD (Registered Dietitian) for intervention...". Review of the facility nurse's notes (except as noted on 6/11/09) revealed the following: 5/12/09- "Allevyn (cushioned dressing) drsg (dressing) to sacral area changed Small area of irritation observed on coccyx (tailbone) 1.0 cm x 0.6 cm." 5/31/09- "Skin check done..." no mention of sacral area.. 6/11/09- (Hospice) nurse's note: "... Spoke to nursing staff about an air mattress to prevent skin breakdown...". 6/12/09- "... hospice nurse... will order a gel overlay for her mattress to trial." 6/14/09 (4 AM)- "Skin assessment performed. Red under R breast. Old bruise on red (sic) elbow noted. Dr. to assess in AM... (12:35 PM) MD assess (sic) above problems..." No mention of sacrum in this entry. 6/15/09- "Resident c (with) ulcer of sacrum 3.2 cm long x 1.8 cm wide, unable (sic) assess depth. Base is 75% yellow slough (stringy, dead tissue) & 25% red c scant serous drainage & pink around the wound."	F 314	B) All residents have the potential to be affected by this deficient practice. A sweep was ompleted on 10/23/09 of all weekly skin check assignments. All (63 residents skin check assignments were properly completed and documented as assigned. C) Nursing Supervisors and or designee will audit all skin assessment assigned on each shift to ensure that they are completed and documented. Nurse assigned to complete skin check will not leave the shift until completed. Supervisor will follow up with disciplinary action with the nurse not completing the weekly skin assessment. All nursing supervisors will receive in-serving regarding their responsibilities with new procedure effective 10/30/09.	10/23/09 10/30/09

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F 314	Continued From page 12 6/16/09 (11:30 AM)- "... Air mattress placed on bed." 6/16/09 (2:10 PM)- "When doing sacral wound treatment... wound was yellow, green slough, also noticed darkened, discolored area approximately 1 cm length x 0.5 cm width. Informed MD no new orders at this time. 6/17/09- (Wound Care Nurse)- Wound measurements to sacral wound stage IV (full thickness tissue loss with exposed bone, tendon, or muscle): w 2.0 x L 3.9 x 0.6 cm. Wound has scant serous-red drainage, wound edges purplish-red, wound bed has 25% granulation (formation of connective tissue and many new capillaries):...". Review of Weekly Skin Integrity and Risk Assessments (weekly skin check) dated 5/10/09, 5/17/09, 5/24/09, and 5/31/09 documented that Allevyn was in place for protection to the sacral area, but failed to document an actual assessment of the skin area. On 6/7/09, the sacrum was not mentioned at all on the weekly skin check and "skin intact" was noted. As previously noted, the weekly skin check on 6/14/09 also failed to mention the sacral area, although a PU had been discovered on 6/12/09, so again, the sacral area was not assessed. According to facility documentation received after the survey ended, R15 "... developed erythema (redness) of the sacral area in August 2008. The sacral area remained intact with preventative care using Allevyn dressing with topical barrier creams to the buttocks... sacral area was found to have developed drainage on... 6/12/2009...". The facility sent an incident report to the DLTCRP (Division of Long Term care Residents	F 314	R 15 D) Corrective actions will be reported to the DON / NQI committee for review until substantial compliance is achieve Supervisors will take immediate corrective action while on shift to assure that skin checks assigned to that shift are completed. A monthly random audit of 20% of skin checks will be done prior to Nursing QI meeting and the results will be reviewed at QI with recommendations made regarding any deficient practice noted.	12/3/09

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F 314	Continued From page 13 Protection) on 6/16/09 which stated that on 6/15/09, a facility treatment nurse (E10) requested the wound care nurse (E18) to evaluate R15's pressure ulcer which was then found to be unstageable. Documents by the investigative unit of the DLTCRP were reviewed, as were investigative documents from the facility. Written statements by a CNA (E18), dated 6/16/09, stated, "On Friday June 12 (2009), while doing AM care on (R15) I smelled a strong odor. When I turned the resident to the side I noticed the dressing (sacral) was half off and the odor was even stronger. I pulled it the rest of the way off and discovered where the odor was coming from. There was an open wound that was draining. I went to get the treatment nurse (E10) to tell her to take a look, she gave me a jar of lantiseptic to apply, I told she needed to come and take a look, because it smelled like decaying flesh...". The facility interviewed E18 on 6/16/09. Statements included, "... wound was the size of a 50 cent piece or so wound was oozing & smelled of rotten flesh...". E18 stated that when E10 tried to give her Lantiseptic to apply, she explained to E10 that "she could put that on the bottom but not on the wound she had to come see it. (E10) came in- looked at wound- (E18) went to trash to pulled (sic) out bandage because it looked messy & wanted (E10) to see it. (E10) smelled it and said it smelled like BM. (E18) disagreed. (E10) placed an allevyn bandage over area w/o (without) cleansing or any other action. (E18) stated it was definitely not BM." E10 was interviewed by the facility on 6/15/09 and E10 agreed to have the notes serve as her	F 314		

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F 314	Continued From page 14	F 314		

statement as well. E10 stated that she was called into E15's room by E18 on 6/12/09 because of smelly drainage on the Allevyn. E10 stated, "smelled it herself, not poop. Did not think should do anything different- she put allevyn back on. Said it was same pink as she had been seeing it- does not remember seeing any yellow but did think about it over the weekend- Today planned to have someone else take a look... (E10) initiated E19 (previous unit manager) looking at this wound in the morning. That observation brought this wound under review...".

E10 was interviewed by the surveyor on 9/23/09. She stated that she did not see an open area on 6/12/09 and "no one believes me." E10 stated that the drainage on the Allevyn did not smell like BM (stated it did smell like BM when interviewed by the facility on 6/15/09)and it was tan. When asked where she thought the drainage came from, E10 stated, "it's a mystery to me." She replied that maybe it was rectal drainage. When asked why she did not report the drainage (change in condition) to the MD, E10 stated she did not know what to tell him as she was unsure where the drainage came from.

R15 expired on 6/17/09. Review of hospice nurse's notes dated 6/11/09 and 6/16/09 did not have the area checked "anticipate death 72 hrs or less".

In summary, the facility failed to provide thorough, accurate weekly skin checks and they failed to provide the necessary care and services to promote the healing of a pressure ulcer documented on 6/12/09. The facility failed to ensure the wound was cleansed or that treatment other than placing an Allevyn dressing over the

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F 314	Continued From page 15 wound was provided. The facility failed to ensure the pressure ulcer was reported to the MD and RD as per facility policy so that appropriate treatment could be initiated. There was a 3 day delay from the time of discovery to the time the wound was reported and when it was reported the wound had progressed to unstageable. Findings were confirmed with E2 (facility administrator) on 9/23/09. She stated that she investigated this and came to the same conclusions.	F 314	A. Once informed of the deficient practice R1, R7 and R13 were seen by the psychologist on 09/29/09 to determined the need for further Gero-Psych follow-up. Progress note was written in regards to the outcome of the discussion with each resident. For R1 : "Pt seen at bedside to again offer services if he needs to make sure he did want to terminate CT. Pt said he is coping well generally and wants to terminate. If he changes his mind at a later date, he will inform staff. For R7 : "Pt is resistive to therapy. Will see only if needed." For R13: "Pt has been seen 9/21 and 9/29 this month. No agitation , no irritability – other than in CBT – discussing his current situation. Continue CBT to process his feelings and thoughts and to improve ability to follow through and plan more effectively. Stabilize emotions through altering his perceptions of situation."	9/29/09
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide care and services to 3 residents, (R1, R7 and R13) out of 15 sampled to reach and maintain their highest level of mental and psychosocial functioning. The facility failed to have a system in place to ensure that psychological services were provided on a regular basis for these three residents who demonstrated a need for therapy. Findings include: 1. R1 was admitted to the facility on 11/9/07 with multiple diagnoses including end stage renal disease, depression and a history of substance abuse. R1's annual history and physical, dated	F 319	B) The physician will write an order for every resident identified as needing either a Gero-Psych evaluation and / or psychiatric evaluation. The Gero Psych team member and /	

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F 319	Continued From page 16 11/9/08, stated that he suffered from chronic depression. He went out of the facility on Mondays, Wednesdays and Fridays for renal dialysis. Review of R1's social service notes revealed a note, dated 3/6/08, that stated, "He told staff that he has thought about suicide." Review of R1's clinical record revealed psychology notes, dated 3/23/09, 3/31/09, 4/13/09 and 4/27/09 each stated that the resident would continue to be followed. The last note, dated 4/27/09, recommended, "CBT (Cognitive Behavioral Therapy) by psychologist continued weekly." No other psychology notes were found until 9/21/09, after the surveyor interviewed the psychologist and asked why the resident had not been seen for five months. Interview with the nurse who schedules consults, E4, on 9/17/09, revealed that the facility had difficulty with the psychologist coming to the facility to see residents every week. She stated that it had been a big problem and that they needed more psych support for the residents. During an interview with R1 on 9/21/09, he stated that he had not seen the psychologist in some time. He added that when she came, it was early on Monday mornings when he was getting ready to go to dialysis and he did not want to talk to her at that time. 2. R13 was admitted to the facility on 4/26/07 with diagnoses including a history of a stroke with left-sided paralysis, chronic obstructive pulmonary disease and personality disorder.	F 319	or psychiatrist will be notified by email of the consult request by RNAC or designee. The Gero-Psych team member and/or psychiatrist will see the resident and complete an evaluation. The physician will read the consultation report and if in agreement with follow up services, e.g.: pychotherapy, the physician will write an order. If psychotherapy is ordered, the resident will be seen on an as needed basis with a progress note written for every encounter. C. All new residents' mental health issues will be reviewed by the physician in order to make a determination as to the need for a mental health evaluation at EPBH. All other residents will be identified by staff and/or physician as in need of mental health services. A physician's order will be written for each resident deemed to need a mental health consult evaluation, written to either or both Gero-Psych and Dr. Chester, psychiatrist. Recommendations for Gero-Psych follow-up services generated by the consultation evaluations as described above	

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F 319	Continued From page 17 A "Gero-Psych Consultation" report, dated 10/20/08, revealed that R13 suffered from "mental illness characterized by cognitive impairments, mood disturbance of anger and chronic delusional disorder." Review of R13's clinical record revealed psychology notes, dated 6/15/09 and 7/6/09, which both stated plans to continue to follow the resident. No other notes could be found until 9/21/09, after the surveyor interviewed the psychologist and asked why R13 had not been seen by a psychologist since 7/09. During an interview with the facility's psychologist, E11, she stated that she went to the facility on Mondays, but if she was unable to go, there was no one else available to fill in for her. When asked how she scheduled residents who were seen regularly, she stated that some of the residents came up to her office to see her on their own, or she called down to the floors for them. She stated that her appointments often conflicted with other therapies. She stated that she randomly checked in with residents to see how they were doing. She further stated that her consults were often, "haphazard" and admitted that a better system was needed to assure that residents were seen regularly. 3. R7 was admitted to the facility on 3/28/07. Diagnoses included Von Hippel-Lindau syndrome, diabetes mellitus, chronic kidney disease, and depression. Review of a 8/24/09 progress note written by the psychologist, stated,"... anxious & distressed... feels a loss of control & sense of helplessness... Geropsych to see weekly until stable."	F 319	will be reviewed by the physician and an order will be written for the Gero-Psych service. Gero-Psych will be advised of this consultation referral by an email alert and placing the consult email request in the Gero Psych file. The Gero-psych team member and/or psychiatrist will follow-up with the service(s) with the resident/patient and a progress note will be written in the medical chart when the patient is seen. If the patient/resident could not be seen for whatever reason, a progress note will be written at least once monthly to describe the service and reasons that the resident could not be seen during the month (e.g. The resident refuses). Physician and responsible party (if resident deemed not competent) will also be notified if that resident is in a crisis but is refusing to be seen, Gero-Psych will do what is necessary to ensure his/her emotional stability despite the refusal. All involved staff will be in-serviced by 10/31/09 D. The Gero-Psych team member will keep a Monthly Gero-Psych Patient Listdescribing the services rendered, the dates rendered, and disposition of	10/31/09

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F 319	Continued From page 18 Although geropsych was to see R7 weekly, he was not seen again by the psychologist until 9/21/09, almost a month later. The 9/21/09 progress note stated, "Psychologist was off 2 Mondays in a row... Emotionally stable... Will be seen upon request." On 9/16/09, the coordinator of psychiatric services (E4) was interviewed. E4 stated that the psychologist (E11) was scheduled every Monday, but when E11 was sick or on vacation, no one filled in and the time was not made up. When asked how many hours E11 worked in the facility per week, E4 stated she was not sure as E11 had not complied with previous requests to put her hours in writing. E4 stated that E11 had worked in the facility for about 2 years. E4 stated that the previous psychologist attended care plan meetings weekly, but E11 does not attend them at all. E4 further stated that the facility had a new admission with psychiatric problems and the facility needed education as they were unsure how to handle the residents behaviors.	F 319	each case.. The RNAC/ designee will maintain a current copy of this list available at all times in the facility. For psychotherapy services, which will be conducted on an as-needed basis ,every encounter will have a progress note. In the event that the patient could not be seen a progress note will reflect this and the reasons why the resident was not seen. This list will be submitted monthly to Nursing Administration. NQI will monitor the timeliness of Gero-Psych services rendered by reviewing the physician's orders and psychologist progress notes and/or consultation reports for the services ordered.	12/3/09
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed	F 323	A) Once informed of medications being left unlocked while unattended, the DON immediately responded by initiating medication error corrective action plan and a review of facility medication administration policy with the nurse on 09/17/09 regarding the fact that no medications are to be left unlocked while the medication cart is unattended. **See Attachment C.**	9/17/09

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F 323	Continued From page 19 to ensure that the resident environment remained as free of accident hazards as possible. On 9/14/09, prescription medications were observed on top of the medication cart unattended and on 9/22/09, a cleaning cart was observed with accessible chemicals, which left the medications and chemicals accessible to residents. Findings include: 1. During the medication pass on 9/1409, medications including Artificial Tears (eye drops), Brimonidine 0.2% eye drops, Timolol 0.25% eye drops, and Fortical nasal spray were observed on top of the medication cart on the third floor unattended. Findings were confirmed with the medication nurse (E15) on 9/14/09, who was in a resident room while the medications were left unattended. 2. On 9/22/09, a cleaning cart was observed in the 200's hallway with the cabinet door ajar into the hallway exposing multiple chemical cleaning agents. A key was observed dangling from the lock by the door. When brought to the attention of the housekeeper, he closed the door.	F 323	B) All residents have the potential to be affected by the deficient practice. C) During supervisory rounds on all shifts, supervisors will assess for medications left unlocked and unattended. Additionally, all nurses will be in-serviced regarding their responsibility to monitor this concern while on the nursing unit, even if not assigned to a medication cart. It will be identified that anyone identifying this situation is to immediately assure that medications are locked or attended to prior to leaving the cart. They are then to complete a medication error report and submit to the supervisor on duty prior to the end of their shift. In-servicing will be completed by October 31, 2009.	10/31/09
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	D) The supervisor who receives the medication error report will immediately speak with the nurse in error and note counseling. The medication error report will be submitted to the nursing office for review and findings will be reported to Nursing Management and presented to the Nursing QI committee monthly for review and possible further correction action based on individual incident.	

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	085022	A. BUILDING _____ B. WING _____	C 09/23/2009

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F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	A) R5 and R 10 continue to be weighed weekly. Any new significant weight changes will be assessed by the Registered Dietitian (RD) and interventions recommended. R 5 has a new usual body weight (UBW) established according to federal regulation standards as of 10/20/09. R 10 had an appropriate usual body weight established.	10/20/09

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F 325	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain acceptable parameters of body weight for one resident (R5) and the facility failed to reweigh R5 and R10 when they experienced weight changes of more or less than 4 lbs. (as per facility policy) and to consistently weigh the residents as ordered. While the dietitian documented significant weight loss for R5, who was at high risk for weight loss, and implemented interventions, R5's desirable body weight (DBW) was incorrectly used to determine her weight loss rather than her usual body weight (UBW). Findings include: The facility "Weights" policy, revised on 2/23/06, stated, "Procedure: ... 4. If the weight taken is 4 pounds more or less the previous weight, the weight measurement is to be taken again (reweigh) immediately by the assigned CNA (certified nurses aide), as an accuracy check. 5. If a reweight is indicated, the scale must be reset after removing the resident from the scale and before reweighing the resident. 6. The weights are documented on the unit "Weight Sheet". 7. The Nurse Manager or Charge Nurse on the unit will review the unit "Weight Sheet" weekly, to screen for any additional reweight measurements indicated... Interdisciplinary Review: ... C. The facility Interdisciplinary Care Planning Team (physician, nurse managers, dietician) will review the significant weight changes at the conclusion of each weekly team conference and make recommendations of interventions to the direct care team. The RNAC will incorporate any new interventions... into the resident's care plan..."	F 325	B) All residents have the potential to be affected by the deficient practice. A sweep of all resident charts was completed by 10/22/09. No resident was found to have been negatively affected as a result of a failure to use usual body weight correctly in the assessment process (0 out of 67 resident sample). C) All new quarterly and annual nutrition assessments completed 10/20/09 or after will establish a UBW or UBW range when possible. UBW will be considered appropriately when assessing weight loss and potential interventions. D) All RD assessments from 10/20/09 forward pertaining to significant weight loss will be tracked over the next 6 months to determine if usual body weight was appropriately used in the assessment process. A tracking sheet will be provided to the social services administrator at the end of 3 month and 6 month period. Findings will be review by the facility QI Committee to ensure compliance.	10/22/09 10/22/09 12/3/09

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F 325	Continued From page 21 1. Diagnoses for R5, a 47 year old female, included advanced multiple sclerosis and chronic back pain. She was wheelchair bound. According to R5's most recent MDS (minimum data set) assessment, a quarterly, dated 7/14/09, R5 had mild cognitive impairment and no short or long-term memory impairment. Review of R5's 2009 weights (wts.) revealed: 1/09- 162.3 lbs. (refused reweight- rewt.) 2/11- 142.1 (rewt.-159.4) 3/4- 149.1 (rewt. 144.1) 3/11- 146.9 (no rewt.) 3/12- weekly wts. ordered for 4 weeks 3/19- 146.0 3/25 138.6 (rewt. 138.8) 4/1 and 4/8- weekly wts. not done as ordered 4/22- 136.3 4/29- no wt. recorded. On 4/30/09 weekly wts. ordered without a stop date. 5/6- 145.4 (listed previous wt. as same, but only recorded here) 5/13- 149.2 5/20 and 5/27- no wts. 6/3, 6/10, 6/17- no wts. Missed 5 weeks of wts.! 6/23- 157.3 (no rewt.). 7/1- no wt. 7/7- 115.1 (no rewt.) 7/15- 113.8 7/21- 119 (rewt. 119) 7/29- no wt. 8/6- 116.2 8/12- no wt. 8/19- 114.2	F 325	A) Once informed of the inaccuracy in weights for R5 & R10, a baseline weight was obtained and documented 10/20/09. B) All residents have the potential to be affected by the deficient practice. Each unit will have an assigned certified nursing assistant to obtain weekly weights and re-weights to maintained consistency. Each assigned CNA received individualized training regarding facility policy. 10/22/09. C) All weights will be review by the RD or designee to determine significant weight changes. Findings will be reported to the unit manager, physician and RNAC. D) All significant weight changes will be reviewed by the IDCC team for dietary recommendations. RD or designee will conduct monthly audits to assure all weights and re-weights are completed and documented as per facility policy. Findings will be reported to DON / NQI Committee.	10/22/09 10/22/09

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F 325	Continued From page 22 8/26- 114.6 9/2- 116 9/6- refused wt. 9/16- 108 (rewt. 120) E14 (CNA) was observed by a surveyor weighing R5 on 9/16/09. She stated she had never weighed her before. E14 correctly subtracted the weight of R5's new electric wheelchair and obtained a wt. of 108 lbs. on the stand-up scale. When asked what to do if there was a wt. discrepancy, E14 stated to use the old scale (Health o meter) to compare wts. and to report it to the charge nurse. E14's response was incorrect as facility policy was to take the resident off the scale, recalibrate and immediately reweigh using the same scale. E5 (unit manager) was interviewed on 9/16/09. She stated that R5 would be reweighed on the sling scale later. R5's rewt. was 120 lbs. E5 stated that they had been having some trouble with their scales and they were recalibrated. Copies were provided of inspections, checks and calibrations of the scales from 4/20/09, 5/26/09, and 7/31/09. Review of the dieticians (RD) notes revealed: 1/27/09- R5's wt. fluctuated between 155-165 for 6 months. Above DBW (desired body weight) of 121-149. 3/13/09- R5 stated to nurse that she was trying to lose wt. and stated to another nurse that she thought it was from loose stools, although neither were observed or complaints documented. Remains at high end of DBW. No apparent changes to documented intake patterns. Continues to go out of facility (OOF) often so total intake not accessible.	F 325	A) R5 and R 10 continue to be weighed weekly. Any new significant weight changes will be assessed by the Registered Dietitian (RD) and interventions recommended to the physician. R 5 has a new usual body weight (UBW) established according to federal regulation standards as of 10/20/09. R 10 had an appropriate usual body weight established. B) All residents have the potential to be affected by the deficient practice. A sweep of all resident charts was completed by 10/22/09. No resident was found to have been negatively affected as a result of a failure to use usual body weight correctly in the assessment process (0 out of 67 resident sample). C) All new quarterly and annual nutrition assessments completed 10/20/09 or after will establish a UBW or UBW range when possible based on availability of information. UBW will be considered appropriately when assessing weight loss and potential interventions. Registered Dietician will assist Nursing Management in in-servicing all nurses regarding use of UBW instead of IBW as was previously done. In-servicing will be completed by 10/31/09.	10/20/09 10/22/09 10/31/09

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F 325	Continued From page 23 3/16/09- follow up with recent wt. loss. Denied any issues with intake/appetite. Resident noted she eats well, especially when OOF. Resident stated she thought wt. loss was from loose stools. 4/28/09- etiology of wt. loss was unclear. R5 declined supplemental shakes and they were not warranted yet (DBW 121-149). Denied appetite problems. Eating outside foods less often. Tray intake up and down, not unusual for R5. Last lab indicated good protein intake. 5/17/09- wt. moving back to 140-160 range. Etiology for recorded wt. loss still unclear. 6/25/09- "... hx (history) of wt. fluctuations... with acceptable BMI (body mass index- 24.6) for demographic. wt. stabilization or gradual loss into IBW (ideal body wt. 135 +/- 10 lbs. or 125-145) is current goal...". 7/21/09- "... Appetite "OK". R5 stated she had been using manual wheelchair (w/c) since loss of electric. Eating outside foods less frequently since funds are gone. R5 unable to think of any menu items she would like more of. "... wt. loss undesired, not expected. Wt. documentation/calculation errors appear to be primary problem with sudden reported loss this month. Nurse unit manager and DON (Director of Nursing) aware. Current wt. 119 appears accurate (observed by this RD) and below IBW/DBW... HS (heathshake- dietary supplement) lunch/dinner." 8/8/09- "... doesn't like the healthshakes... declined to try ensure (supplement)... Despite reported wt. loss... maintained good protein status as indicated by albumin level... wt. loss likely the result of increased activity using manual wc (wheelchair) as primary ambulation method after electric wc broke. Sudden drop in wt. appears to be a problem with previous wt. inaccuracies. Unit manager/DON made aware of concerns... Some	F 325	D) All RD assessments from 10/20/09 forward pertaining to significant weight loss will be tracked over the next 6 months to determine if usual body weight was appropriately used in the assessment process. A tracking sheet will be provided to the social services administrator at the end of 1 month, 3 months and 6 month period. Findings will be reviewed by the facility QI Committee to ensure compliance with use of UBW and to identify any potential concerns regarding weight loss or gain. A) Once informed of the inaccuracy in weights for R5 & R10, a baseline weight was obtained and documented 10/20/09 for both residents. Upon dietary evaluation neither resident was harmed because of this deficient practice. B) All residents have the potential to be affected by the deficient practice. Each unit will have an assigned certified nursing assistant to obtain weekly and monthly weights and re-weights to maintained consistency. Each assigned CNA received individualized training regarding facility policy. 10/23/09. Policy enclosed.	10/20/09 10/23/09

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F 325	Continued From page 24 gradual wt. gain desirable at this time...". 8/18/09- "... unable to articulate any new preferences. Continues to decline supplements. With some probing... agreeable to... 1) yogurt with hs (bedtime) snack 2) Bagged chip snacks q (every) lunch." 9/14/09- "... denied any issues with appetite... declined any supplementation... indicated she thought she might gain wt. now that she doesn't have to use manual w/c... Some gradual wt. gain still desirable. No significant wt. changes noted since 7/21... continue to monitor... No new preferences voiced...". A nurse's note, dated 3/8/09, stated that R5 had a significant wt. loss of 15.3 lbs. although she ate 100% of meals. On 3/9/09, a nurse's note stated that the MD, RD, RNAC, and ADON were notified via email about R5's wt. loss. It was also noted that R5 made her own food choices. On 8/18/09, a "Medical Nutrition Therapy Consult Report" was completed in which the MD was advised that R5's "caloric intake may be inadequate...". The MD responded on 8/1/8/09 that he agreed with the yogurt and bagged chips as previously discussed. The RD (E7) was interviewed on 9/11/09 and he stated there was no obvious reason for R5's wt. fluctuations and current loss. E7 stated that he thought it was related to wt. inaccuracies, that the same person does not always do the wts. or ensure what items are on the wheelchair. He further stated that R5 was non-compliant with supplements. During another interview with the RD on 9/20/09, he stated that he thought R5's wt. loss was partially due to her not eating out of the facility as much and he stated that R5 had been	F 325	C) All weights will be review by the RD or designee to determine significant weight changes. At the time identified, significant weight losses/gains will be reported immediately to the unit manager, physician and RNAC. Any weights perceived by the RD to be potentially inaccurate will be reported to the charge nurse at the time noted for an immediate re-weight. D) All significant weight changes will be reviewed by the RD and IDCC team weekly for dietary recommendations. RD or designee will conduct monthly audits to assure all weights and re-weights are completed and documented as per facility policy. Findings will be reported to DON / NQI Committee and corrective action taken as determined by findings.	12/3/09

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F 325	Continued From page 25 discussed in the Interdisciplinary Care Planning Team. R5 was interviewed on 9/17/09. She denied that she had tried to lose wt. this year, denied changes in her appetite and meal intake, and stated that she felt fine. R5 stated that she thought using a manual wheelchair for several months may have contributed to her current wt. loss as well as hoeing in the garden this summer. R5 denied that she had any changes in eating out or in eating from the vending machine and she did not believe they were a factor in her wt. loss. Although the dietitian circled significant wt. losses of 5% in 30 days, 7.5 % in 90 days, 10% in 180 days and 15% in 365 days in his 7/21/09 quarterly nutrition assessment, for example, he failed to use R5's UBW to determine her wt. loss. The formula used to determine percentage of wt. loss is % of body wt. loss= (usual wt.- actual wt.)/ (usual wt.) x 100. The facility was unable to accurately determine R5's wt. loss as her DBW (desirable body wt.) was incorrectly used in place of R5's UBW. Accordingly to R5's annual MDS assessment, dated 4/23/07, R5 was 143 lb. On her annual MDS assessment, dated 1/22/08, she weighed 150 lbs. and on her annual MDS assessment, dated 1/20/09, she weighed 162 lb. According to the MDS weights and her wts. as listed above, R5's usual body wt. range was about 143-165 lb., not 121-149 as determined by the RD. Additionally, the facility failed to consistently do wts. as ordered and rewts. as indicated for R5 despite major wt. fluctuations. Additionally, not all staff knew the procedure for rewts. The above inaccuracies lead to the facility failure of not identifying a slow insidious weight loss for	F 325		

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F 325	Continued From page 26 R 5. The facility failed to develop a care plan to address an actual weight loss and incorrectly care planned for maintenance of the desired body weight demonstrating that the facility failed to use the usual body weight for R5. Additionally the facility continued to be incorrectly focused on inaccurate weights instead of her actual weight loss. 2. R10 was admitted to the facility in 1996 with diagnoses of spinal cord injury with quadriplegia and paranoid schizophrenia. Review of R10's 2009 wts. revealed: 1/7- 206.4 lbs. (199.7 lbs. on previous wt.- refused rewt.) 2/11- 210 (rewt. same) 3/09 (no specific date listed)- 194.3 (no rewt.); wts. changed to every 2 weeks 3/31- 219.5 (rewt. 197.3) 4/15- 223.7 (no rewt.)0 4/22- 222.5 5/6- 242.1 (rewt. same) 5/14- 210.5 (no rewt.) 5/20- 213.8 5/27- no wt. done 6/3 and 6/10- no wts. done 6/17- 213 (rewt. same) 6/23- 211.5 7/1- 213.7 (rewt. 209.9) 7/7- 209.9 7/14- 225 (rewt. 205) 7/22- 204.8 7/29- 199.6 (no rewt.) 8/6- 165.4 (rewt. 204.5 and 204) 8/12- no wt. done 8/19- 197.1 (no rewt. done) 8/26- 205 (rewt. same) 9/3- 227 (refused rewt.)	F 325		

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F 325	Continued From page 27 9/9- 196.1 (rewt. 196.3) Review of the dietitian's (RD) notes revealed a quarterly nutrition assessment, completed around 2/11/09 (no date on copy), which stated that R10's DBW (desirable body wt.) was 171-209 lbs. and he still required TF, in addition to meals to meet his needs secondary to psych issues and inconsistent intake. On 3/28/09, the RD stated, "... Sig wt. loss follows significant wt. gain of unclear etiology. Suspect inaccurate wts. as intake levels have not drastically changed...". On 4/21/09, the RD noted sig. wt. gain and stated that R10 appeared to have visibly gained wt. He stated that the 3/13 wt. of 194.3 was "likely inaccurate." On 5/8/09, The RD stated, "... No apparent etiology for an additional 20 # (lb.) wt. gain... should have lost wt. d/t (due to) overnight feeding (TF) being d/c'ed (discontinued). Suspect inaccurate wt.... Nursing unit manager aware of fluctuations...". An annual assessment, completed about 5/20/09 (no date on copy) stated that R10 had wt. loss as desired as he had unexpectedly moved above his IBW/DBW range. Continue weekly weights to monitor wt. loss...". The facility was unable to accurately determine R10's wt. gains and losses as his DBW (desirable body wt.) was incorrectly used in place of his UBW. Additionally, the facility failed to consistently do wts. as ordered and rewts. as indicated for R10 despite major wt. fluctuations.	F 325		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		

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	085022	A. BUILDING _____ B. WING _____	C 09/23/2009

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F 333	Continued From page 28 by: Based on observation, record review and interview it was determined that the facility failed to be free from a significant medication error for 1 resident (SS #22). On 9/14/09, during the medication pass, the medication nurse was stopped from administering the incorrect dosage of Primidone (seizure medication) to SS #22. Findings include: Review of SS #22's medication orders included, "Primidone 250 mg tablet take one tablet po (by mouth) at 0830 (8:30 AM) and at 2030 (8:30 PM)" and "Primidone 50 mg tablet take 2 tablets once daily at 1630 (4:30 PM)". On 9/14/09, at approximately 9 AM, the medication nurse (E16) was observed to have poured 50 mg of Primidone in the medication cup for SS #22 that she was prepared to administer, instead of the 250 mg that was due. E16 incorrectly removed one 50 mg Primidone from the packet with instructions which stated to give two 50 mg tablets at 4:30 PM, instead of taking 250 mg Primidone from the packet which stated to give one at 8:30 am and 8:30 PM. E16 would have administered only 1/5 the dosage of seizure medication that was ordered had she not been stopped by the surveyor. Findings were confirmed with E16 immediately after the medication error occurred. Findings were discussed with E1 (Facility Director) on 9/14/09. She stated that the facility was looking into a new medication packaging system that would reduce the potential for errors such as this.	F 333	SS #22 A) Once informed of incident, the DON immediately responded by initiating medication error corrective action plan and a review of facility medication administration policy with the nurse on 09/18/09. **See Attachment D.** B) All residents have the potential to be affected by the deficient practice. C) Random audits will be conducted by Unit Manager and Nursing Supervisors bi weekly to ensure compliance. D) Audit findings will be reported to the DON / NQI committee for review until substantial compliance is achieve	9/18/09 11/30/09 12/3/09
F 364 SS=E	483.35(d)(1)-(2) FOOD	F 364		

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F 364	Continued From page 29 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures. Findings include: During the resident council group meeting on 9/10/09, three (3) of eleven (11) residents stated that their meals were not always served hot enough. In individual resident interviews throughout the survey, four (4) residents, R1, R3, R5 and SS#23 complained that food was not served hot. On 9/15/09, two resident trays were tested from both floors. The tray from the second floor contained a meatball sandwich. The temperature of the meatballs was 126.5 degrees F and tasted lukewarm. The tray from the third floor contained rice that was 129 degrees F, green beans that were 127 degrees F and swedish meatballs that were 114.5 degrees F. The rice and the green beans tasted lukewarm and the meatballs were cool. None of the food that was supposed to be served hot was warm enough to be palatable. Findings were reviewed with the facility's dietitian, (E7) on 9/15/09.	F 364	A) A replacement tray was already provided to the individuals assigned to the test trays. Any future findings or reported incidents, food to be reheated on unit in microwave when appropriate or a replacement tray will be provided. B) All residents that receive meal trays from Dietary have the potential to be affected in regards to food temperatures based on the desired preference. When notified, resident(s) will be sent a replacement meal tray. C) Staff re-trained on proper placement of tray lids; using two trays when necessary to ensure lid fits properly due to number of items or size of items on the tray. Train staff to use lids to cover foods on serving line to maintain higher temperatures on items that don't hold heat well when plated, Re-trained staff to stir food while tray line is in service. Change procedure for warming plates and dishes; plate warmers will be left on while tray line is in service. Facility is seeking approval to purchase a new tray distribution	9/9/09 9/10/08
F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from	F 412		

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F 364	Continued From page 29 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures. Findings include: During the resident council group meeting on 9/10/09, three (3) of eleven (11) residents stated that their meals were not always served hot enough. In individual resident interviews throughout the survey, four (4) residents, R1, R3, R5 and SS#23 complained that food was not served hot. On 9/15/09, two resident trays were tested from both floors. The tray from the second floor contained a meatball sandwich. The temperature of the meatballs was 126.5 degrees F and tasted lukewarm. The tray from the third floor contained rice that was 129 degrees F, green beans that were 127 degrees F and swedish meatballs that were 114.5 degrees F. The rice and the green beans tasted lukewarm and the meatballs were cool. None of the food that was supposed to be served hot was warm enough to be palatable. Findings were reviewed with the facility's dietitian, (E7) on 9/15/09.	F 364	system (see attached quote). If approval is denied for a completely new system, our second option is to purchase four closed carts to delivery meal trays to units which will increase the retention of heat. D) Daily food temperatures are logged by cook for each meal served. Dietician Assistant conducts a weekly test on random tray for temperature, quality, and appearance after a 30 minute lag. Example of findings attached. The Food Service Director, Cook Supervisor, and Sr. Foodservice Workers will monitor and check serving line to ensure staff follow establish guidelines. Feedback at Monthly Resident Council Meeting	12/8/09
F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from	F 412		

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F 412	Continued From page 30 an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: The facility failed to provide routine and recommended dental services for one resident, (R1) out of 15 sampled residents covered by Medicaid. Findings include: R1 was admitted to the facility on 11/9/07. Review of his dental records revealed that he was seen by the dentist on 12/6/07 for an initial exam, which indicated that he had missing teeth and was at risk for periodontal disease. Recommendations included x-rays, cleaning, restoration of broken teeth and treatment for periodontal disease. No other dental consults were found until 3/19/09 which was in response to a 3/12/09 consultation request by R1's physician for "Grinding teeth." The dentist's response stated that the grinding (bruxism) was due to anxiety. A consultation request from R1's physician, dated 3/22/09, to the dentist requested that a tooth guard be fabricated to treat the resident's bruxism. The dentist responded on 4/2/09 with a request for a sedative that could be given to the resident for treatment. On 3/26/09 another consultation request was sent to R1's physician	F 412	A. Resident affected by deficient practice, R1, was seen in dental clinic on October 15, 2009. R1 signed Consent for Dental Treatment form on 10/16/09 and form forwarded to Dental Clinic. B. All residents have potential to be affected by deficient practice. A sweep of all residents and annual appointments completed on 10/20/09. All residents found to be in compliance with being seen minimally on an annual basis. Dental Clinic is held one day per week for routine examinations and services available prn for more urgent issues. C. Central Intake at DHCI completes all admission paperwork including signature for Consent for Dental Treatment. Upon admission at EPBH, social services/designee will copy consent, place original in dental department's mailbox and place a copy in resident's social services file. If not in initial admission paperwork, EPBH Social Services/designee will	10/16/09 10/20/09

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F 412	Continued From page 31 by the dentist for medical management for dental treatment at which time the physician responded to give prophylaxis antibiotics and hold aspirin for 3 days prior to treatment. A subsequent consultation request was sent by the dentist to R1's physician on 4/7/09 again asking for a sedative to be ordered for the resident's dental treatment for a bite guard, however, there was no response by the physician. During an interview with R1 on 9/14/09, he stated that he was examined by the dentist a few months ago after complaining of sore teeth, but that nothing was done and that he had been waiting to hear back from the dentist. He also stated that he had never had his teeth cleaned since he had been in the facility. In an interview with the facility's dentist, E12, he stated that R1 was seen by dental shortly after he was admitted on 12/6/07 for an initial screening and evaluation and he confirmed that he recommended x-rays, cleaning, restoration of broken teeth and treatment for periodontal disease. He stated that R1 was never provided treatment because he did not have a signed consent form. He also stated that any treatment given to a resident must be initiated by the physician. When R1 was referred to dental in 3/09 for sore teeth, he was evaluated and it was determined that it was due to him grinding his teeth and a mouth guard was recommended. He stated that he sent a consult request to R1's physician for a sedative to treat the resident, but never received a response. During an interview with R1's physician, E13, on 9/22/09, he disagreed that his approval was needed for residents to have dental treatment.	F 412	complete consent. Upon admission, EPBH's physician will write an order for an initial dental consult. The consult is placed in the dental department's mailbox by nursing operation support specialist/designee. Dental Clinic Assistant completes an appointment form upon receipt of consent form and this form is placed in nursing department mailbox prior to date of actual appointment. If Dentist writes consult for physician regarding treatment needs, this consult is placed in nursing dept. mailbox and then delivered to nursing unit. Upon receipt of consult by nursing, the form is placed in the physician's folder for his review and signature. Upon signature, the nursing dept. will place copy of consult back in dental dept. mailbox. All nurses, dental assistant, physician, dentist and nursing support staff will be in-serviced on procedure by 10/31/09.	10/31/09

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F 412	Continued From page 32 He stated that the dentist sometimes consulted with him on treatment when there was a medical need. When asked why he failed to respond to E12's consultation request for a sedative to provide treatment for R1, he stated that "he must have missed that one." R1 has resided at the facility since 11/9/08, almost two years, and has never received routine cleaning or dental care. The facility failed to provide necessary dental care for this resident due to a lack of coordination between dental services and this resident's physician.	F 412	D. The Dental Assistant will maintain a log of any consult written by the Dentist and will contact the Nursing Department if copy of consult not returned to Dental Clinic with physician signature signifying reviewed and outcome of review. Dental Assistant will notify her immediate supervisor of any consult not returned within 7 working days. If consult identifies immediate need, the dental assistant will notify her supervisor, who is the Social Service Administrator. The supervisor will then review concerns with Nursing Management and Physician for a plan of action..	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: September 23, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from September 9, 2009 through September 23, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 66. The survey sample totaled fifteen (15) residents, which included a review of thirteen (13) active and two (2) closed clinical records. Additionally, there were eight (8) subsampled residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	

Provider's Signature K. Mitchell Title Administrator Date 10/26/09

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	Cross-refer to CMS 2567-L, survey date completed 9/23/09, F309, F314, F319, F323, F325, F412.	Cross refer to POC survey dated completed 9/23/09; F 309 Pgs. 6,7,8,9, and 10; F 314 Pgs. 10,11,12,13,14, and 15; F 319 Pgs. 16,17,18, and 19; F 323 Pgs. 19 and 20; F325 Pgs. 20, 21, 22, 23,24, 25, 26, 27, and 28; F 412 Pgs. 30.
3201.6.11	**Medications**	
3201.6.11.1	**Medication Administration**	
3201.6.11.1.5	**Medications shall be given only to the individual resident for whom the prescription or order was issued, and shall be given in accordance with the prescriber's instructions.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L, survey date completed 9/23/09, F333.	Cross refer to POC Survey date completed 9/23/09 F 333 Pg. 29
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food Code.**	
	This requirement is not met as evidenced by:	
	Based on the dietary observations on 9/9/09, it was determined that the facility failed to comply with sections 4-903.11 (B) (1), 4-601.11 (B), 3-305.11 (A) (3), and 6-201.11 of the State of Delaware Food Code.	

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	4-903.11 Equipment, utensils, linens, and single-service and single-use articles. **(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:** **(1) In a self-draining position that allows air drying.** **This requirement is not met as evidenced by:** Observations in the AM of the ready-to-use rack revealed that a stack of seven (7) steam table pans and three (3) clear plastic containers were dripping wet. **4-601.11 Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils.** **(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.** **This requirement is not met as evidenced by:** Observations at 8:27 AM of the ready-to-use rack	A) No residents were affected by this finding. Food Service Director removed pans and re-sanitized and dried properly immediately upon finding. B) All residents that receive meal trays from Dietary have the potential to be affected by not properly air drying equipment and utensils. Equipment and utensils found to not be in a self draining position will be rewashed, sanitized, and dried correctly. C) Shift supervisor will be responsible to check and remove pans that are not properly dried. Additional space has been designated for drying pots pans and utensils if needed. All dietary staff retrained on food code regulations related to proper cleaning of equipment and utensils on 9/9/09 and 9/10/09. D) The Food Service Director, Cook Supervisor, and Sr. Food Service Workers will provide additional monitoring to ensure all items are dried according to code. Findings and feedback will be discussed at Monthly staff meeting. Ongoing

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	4-903.11 Equipment, utensils, linens, and single-service and single-use articles. **(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored:** **(1) In a self-draining position that allows air drying.** **This requirement is not met as evidenced by:** Observations in the AM of the ready-to-use rack revealed that a stack of seven (7) steam table pans and three (3) clear plastic containers were dripping wet. **4-601.11 Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils.** **(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.** **This requirement is not met as evidenced by:** Observations at 8:27 AM of the ready-to-use rack	A. No residents were affected by this finding. Food Service Director removed pans and re-washed several times immediately upon finding. The three pans found were discarded after several attempts to remove debris where unsuccessful. B. All residents that receive meal trays from Dietary have the potential to be affected by pans used that are not free from debris. Pans, equipment, or utensils found not clean will be re-washed, sanitized, and dried correctly. Items not able to be cleaned will be discarded. C. Cook supervisor will be responsible to check and remove pans, equipment, or utensils that are not in sanitary condition. All dietary staff retrained on food code regulations related to proper cleaning of equipment and utensils. D. The Food Service Director will provide additional monitoring to ensure all equipment is replaced timely and maintained according to code. Findings and feedback will be discussed at Monthly staff meeting. Completed 9/9/09

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	revealed that the food contact surfaces of the top pan of a stack of three (3) cupcake pans was soiled with brown debris. **3-305.11 Food storage.** **(A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food:** **(1) At least 15 cm (6 inches) above the floor.** **This requirement is not met as evidenced by:** Observations at 8:40 AM of the walk-in freezer with the Food Service Director (E6) revealed that two (2) cardboard containers of cob corn were stored on the freezer floor. **6-201.11 Floors, walls, and ceilings.** **Except as specified under § 6-201.14, the floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable, except that anti-slip floor coverings or applications may be used for safety reasons.** **This requirement is not met as evidenced by:**	A) No residents were affected. Boxes identified were immediately inspected and placed properly in the storage area. B) All residents that receive meal trays from Dietary have the potential to be affected in regards to food not being stored properly. Additional food supplies were purchased due to a resident event scheduled the weekend. The storage needs required moving items to obtain other items and resulted in the staff error. When this occurs in the future, additional storage will be made available and organized in a manner to reduce the need to move site. C) Cook Supervisor and Supply Tech will oversee the stocking of all supplies received on a daily basis. All dietary staff retrained on stocking procedures per regulations on 9/9/09 and 9/10/09. D) Cook Supervisor and Supply Tech will inspect storage areas daily. Supply Tech will maintain all storage areas to comply with FDA Food Code standards. Food Service Director will inspect storage areas randomly but no less than monthly to ensure compliance. Ongoing

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	Cross-refer to CMS 2567-L survey date completed 9/23/09, F253.	Cross refer to POC Survey date completed 9/23/09 F 253 Pg 29 Pgs. 5 and 6.
16 Del., C., Chapter 11, Subchapter III, § 1131	Definitions (9) Neglect shall mean: b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 9/23/09, F224.	Cross refer to POC Survey date completed 9/23/09 F 224 Pgs. 1 and 2.
16 Del. C., Chapter 11, Subchapter III, § 1132	Reporting requirements (a) Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A	

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DATE SURVEY COMPLETED: September 23, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	written report shall be filed by the employee or service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 9/23/09, F225.	Cross refer to POC Survey date completed 9/23/09 F 225 Pgs. 4 and 5.